UTAH STATE MEDICAID
ICF/MR FACILITY

State Fiscal Year 2008

QUALITY IMPROVEMENT INCENTIVE APPLICATION

This form and all supporting documentation is due on or before June 8, 2008

Facility Name: _____ I.D. #_____

Administrator: _____

Please mark all that are complete:

☐ This facility received no violations that are at the IJ level, as determined by the Department, during the incentive period.

☐ This Facility has a Quality Improvement plan which includes the involvement of residents and family. *(A brief description of our Quality Improvement Plan is attached.)*

☐ This facility has a process by which our Quality Improvement plan is assessed and measured. *(A brief report describing this process and which includes an example demonstrating how the facility assessed, responded to and re-evaluated a clinical quality concern, is attached.)*

Please ensure that the attached documents do not exceed a total of 10 pages.

Administrator Signature:_____ Date:_____